NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities

FRAGILE X MOLECULAR ANALYSIS

IBR SPECIALTY CLINICAL LABORATORIES

1050 Forest Hill Road, Staten Island, New York 10314-6399 (718) 494-5293 FAX (718) 494-4835 CLIA #33D0860102

PATIENT NAME *(Last, First, M.I.)* _____ Date of Birth _____ Sex ☐M ☐F

Street Address _____ Phone # _____

City _____ State _____ Zip _____

ETHNICITY: ◯Caucasian ◯Hispanic ◯Afro American ◯Asian ◯American Indian ◯Other _____

The purpose of this test is to examine a region of DNA within the fragile X gene. The test consists of DNA analysis of the CGG repeat associated with fragile X syndrome, a common cause of inherited intellectual disabilities. A positive test indicates that the individual is a carrier or is affected by fragile X. The test is ~99% accurate, but rare diagnostic errors may occur. No tests other than those authorized or needed to confirm a result shall be performed on the sample and it will be discarded 60 days after receipt unless you give permission below to use any extra sample for research. You may seek genetic counseling if you wish.

I understand the above and give consent for diagnostic testing only:

_____

Name (printed and signature) of Subject or Parent or Guardian *Date* *Witness (printed and signature)*

I give permission for any extra sample to be saved and used for future research related to developmental disabilities or distributed to another investigator for the same purpose. I understand that samples will be coded to protect my confidentiality. I understand the research will not include whole genome sequencing. I authorize the laboratory to store such samples for an indefinite period of time. I may, however, withdraw my permission without penalty, at which time the sample will be destroyed.

I understand the above and give consent for diagnostic testing and to use the remaining sample for research:

_____

Name (printed and signature) of Subject or Parent or Guardian *Date* *Witness (printed and signature)*

NOTE: The information on this referral form is confidential and is under the protection of the HIPAA Privacy Rule of 1996. If it has arrived at the wrong address, please destroy this form and notify us as soon as possible. Thank you.

PATIENT INSURANCE INFORMATION	INSTITUTIONAL BILLING
Name of Policy holder _____	Name _____
Relationship to patient _____	Address _____
Attach a copy of both sides of patient's insurance card	Phone _____ FAX _____

REASON FOR TEST

Mental Impairment ☐Yes ☐No

In a Family member ☐Yes ☐No

If yes, name(s) _____

Positive test for fragile X ☐Yes ☐No

Name(s) _____

Lab _____

If yes: ◯Intermediate ◯Premutation ◯Full Mutation

Is a pregnancy involved? _____ EDC _____ Other reason for the test? _____

REFERRAL INFORMATION

Physician name (printed and signature)

Telephone # _____ FAX # _____ Address _____

NPI # _____ City, State, Zip _____

Genetic Counselor

Telephone # _____ Address _____

FAX # _____ City, State, Zip _____

SPECIMEN TYPE

◯Blood: 10 ml lavender tube ◯Amniotic fluid: 10 ml ◯CVS 5-10 mg Collection date: _____

◯Cultured CV ◯Cultured AF ◯Saliva US date: _____ Gest. age by US date: _____

DIAGNOSIS *(check all that apply)*				☐ Genetic carrier of other disease	Z14.8
☐ Autism Spectrum Disorder	F84.8	☐ Severe intellectual disabilities	F72	☐ Maternal care for (suspected) hereditary disease in fetus, not applicable or unspecified	O35.2XXO
☐ Mild intellectual disabilities	F70	☐ Profound intellectual disabilities	F73	☐ Family history of intellectual disabilities	Z81.0
☐ Moderate intellectual disabilities	F71	☐ Delayed milestone in childhood	R62.0	☐ Family history of carrrier of genetic disease	Z84.81